First lecture: Health assessment / Health history

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Introduction

Health assessment is "a dynamic and continuous process of collecting, verifying, and organizing information about a person within a particular context for the purpose of planning patient centered care."

Types of assessment

1. Initial comprehensive assessment.
2. Ongoing or partial/shift assessment.
3. Focused or problem-oriented assessment.
4. Emergency assessment.
5. Time-lapsed assessment.

Component of health assessment

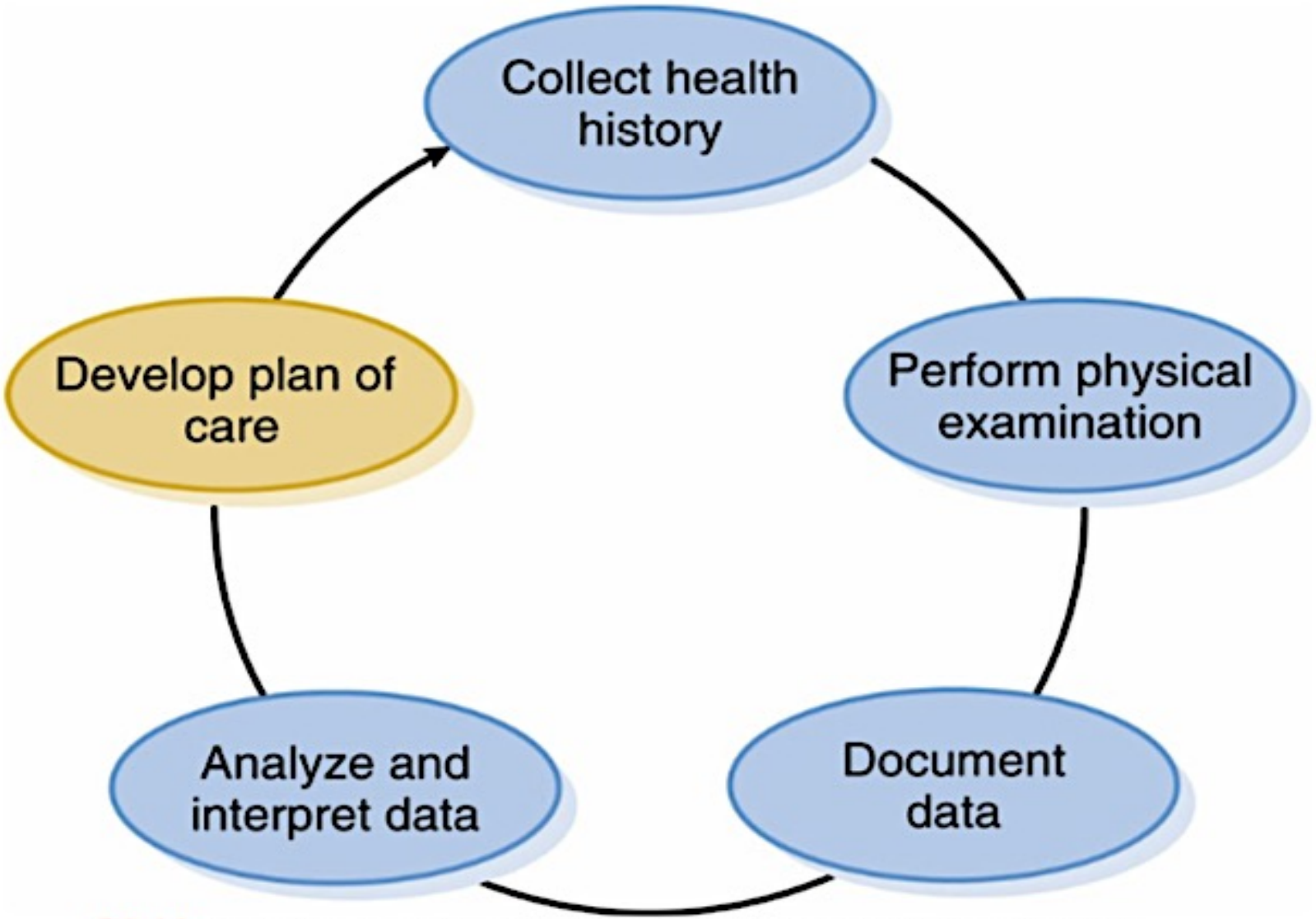

FIG. 1-1 Health history, examination, data documentation, and data analysis are antecedents to developing a plan of care.

Health History

A health history consist of the subjective data collected during an interview

Components of health history:

- Demographic information
- Reason for seeking health care
- History of the present illness
- Past health history
- Family medical history
- Review of systems
- Lifestyle practices/Nutrition
- Current medication
- Psychological history
- Sociocultural history

General Guidelines for Interviewing to Obtain Health History

- Greeting client, introduce self and establishing rapport. Use appropriate title Quickly review the patient's chart (to provide you with an idea of the patient and will avoid asking repetitive questions).
- Setting goals for the interview.

- Improving the environment. It should be private, quiet and uninterrupted.
- Taking Notes.
- Inviting the Patient's Story. Begin with open-ended questions that allow full freedom of response, e.g.—What brings you to the hospital?‖Inquire how client is feeling; watch for signs of discomfort such as evidence of pain or anxiety.
- Listen actively for important symptoms, emotions, events and relationships. Be empathetic and caring
- Be professional- nonjudgmental, concerned and informed.
- Reactions as disapproval, impatience (nonverbal behaviors) block communication.
- Assure confidentiality.
- Assure clients that the information you collect will be shared only with the health care team

BOX 2-1 Phases of an Interview

Introduction Phase

Nurse:

- Introduces self to the patient.
- Describes the purpose of the interview.
- Describes the interview process.

Discussion Phase

Nurse:

- Facilitates and maintains a patient-centered discussion.
- Uses various communication techniques to collect data.

Summary Phase

Nurse:

- Summarizes the data with the patient.
- Allows the patient to clarify the data.
- Communicates an understanding of the problems to the patient.

Frequently Asked Questions

What are the most important things the nurse should do to ensure a successful interview with a patient?

Listed below are several tips to enhance the success of an interview that are associated with the preparation and the interpersonal communication skills of the nurse.

- **Make a good first impression.** A professional greeting is essential to establishing initial rapport. The nurse should consider his or her personal appearance and body language.
- **Be prepared.** Review the patient's medical record (if it is available) before meeting the patient. This not only helps the nurse anticipate some of the issues that may arise, but it also lets the patient know that you are interested enough to invest time prior to the first meeting.
- **Be an attentive listener throughout the interview.** Sometimes nurses can become so concerned with documentation, they forget to engage in the process of communication.
- **Use questioning techniques to optimize the conversation.** This helps the nurse collect the information needed.
- **Avoid using medical jargon.** Keep the conversation as simple as appropriate; make sure the patient understands the information you are sharing with him/her.

BOX 1-2 Clarification of Terms

Signs and Symptoms

- *Signs* are objective data observed, felt, heard, or measured. Examples of signs include rash, enlarged lymph nodes, and swelling of an extremity.
- *Symptoms* are subjective data perceived and reported by the patient. Examples of symptoms include pain, itching, and nausea.

Occasionally data may fall into both categories. For example, a patient may tell the nurse that he "feels sweaty"—a symptom. At the same time the nurse may observe excessive sweating, or diaphoresis—a sign.

Clinical Manifestation

Clinical manifestation is a term often used to describe the presenting signs and symptoms experienced by a patient.

1- Demographic information

- Name
- Gender
- Address
- Type of health insurance
- Date of birth
- Race
- Occupation

2- Reason for seeking health care/ chief complain

- It is important to get the chief complaint in the patient‘s own words.

History of the present illness/ COLDSPA

C- Character (the quality of feeling or sensation, e.g. sharp, dull, and stabbing).

O- Onset/Timing (onset, duration, frequency, and precipitating factors of the symptoms).

L- Location (area of the body in which symptom is felt).

D- Duration

S- Severity/Intensity (the severity or quantity of the feeling).

P- Pattern (Aggravating/Alleviating factors/activities or actions that make the symptom better or worse).

A- Associated factors/How it affects the client (What other symptoms occur with it? How does it affect you?)

Past health history

- Major illnesses or previous hospitalizations and surgical procedures.
- Allergies (food, drug, and airborne allergies).
- Previous injuries/Fractures.
- Childhood diseases/Immunizations (history of polio, measles, mumps, and rubella).

Family medical history

- Diabetes mellitus.
- Allergic disorders.
- Cardiovascular problems and race.

Review of systems

- A brief account from the client of any recent signs or symptoms associated with any of the body systems.
  - It reveals data related to present illness.
  - The review of systems checklists are often used to ask about:

General: Usual weight, recent weight change. Weakness, fatigue, or fever.

Skin: Rashes, lumps, sores, itching, dryness, color change, changes in hair or nails.

Head: Headache, head injury, dizziness.

- **Eyes:** Vision, glasses or contact lenses, redness, excessive tearing, double vision, blurred vision, flashing lights, glaucoma, cataracts. **Ears:** Hearing, tinnitus, vertigo, earaches, infection, discharge. If hearing is decreased, use of hearing aids.
- **Nose and sinuses:** Frequent colds, nasal stuffiness, discharge, or itching, nosebleeds and sinus trouble.

- **Throat (or mouth and pharynx):** Condition of teeth, gums, bleeding gums, dentures, sore tongue, dry mouth, frequent sore throats, and hoarseness.
- **Neck: Lumps, —**swollen glands,‖ goiter, pain, or stiffness in the neck.
- **Breasts:** Lumps, pain or discomfort, nipple discharge
- **Respiratory system:** Cough, sputum (color, quantity), hemoptysis, dyspnea, wheezing, pleurisy, last chest x-ray.
- **Cardiovascular.** Heart trouble, high blood pressure, rheumatic fever, chest pain or discomfort, palpitations, dyspnea, orthopnea, and or edema.

- **Gastrointestinal system:** Heart burn, appetite, trouble swallowing, nausea, change in bowel habits, rectal bleeding hemorrhoids, abdominal pain, constipation, diarrhea, passing of gas, food intolerance and/or excessive belching.
- **Urinary system.** Frequency of urination, polyuria, nocturia, urgency, burning or pain on urination, hematuria, incontinence; reduced force of the urinary stream, hesitancy and/or dribbling of urine in males.

- Genital. Male: Hernias, discharge from or sores on the penis, testicular pain or masses.
- Female: Age at menarche; regularity, frequency, and duration of periods; amount of bleeding, last menstrual period; dysmenorrhea, number of deliveries, age at menopause, menopausal symptoms, postmenopausal bleeding.

- **Peripheral Vascular:** leg cramps, varicose veins, past clots in the veins.
- **Musculoskeletal system:** Muscle or joint pains, stiffness, arthritis, gout, and backache. Presence of any swelling, redness, pain, stiffness, weakness, or limitation of motion or activity; include timing of symptoms (e.g. morning or evening)
- **Neurologic system:** Fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling, tremors or other involuntary movements.

- **Hematologic:** Anemia, easy bruising or bleeding, past transfusions and/or transfusion reactions.
- **Endocrine:** Thyroid trouble, heat or cold intolerance, excessive sweating, excessive thirst or hunger, polyuria.
- **Psychiatric:** Nervousness, tension, mood, including depression, memory change.

Lifestyle practices/Nutrition

- Hygienic practice
- Skin exposure
- Habits (the use of alcohol, drugs caffeine and tobacco use).
- Activities of daily living (ADL‘s) [bathing, toileting, transfer, eating, dressing].
- Eating pattern.

Current medication

- Steroids, antibiotics, antihypertensive drugs, hypoglycemic drugs, vitamins, hormones or chemotherapy.

Psychological history

- The assessment of dimensions as self-concept and self-esteem.
- Sources of patient's stress and ability to cope.
- Sources of support for clients in crisis, such as family, significant others, religion, or support groups.
- Community involvement: Church involvement, volunteer work, employment, hobbies, group memberships, social and/or recreational programs, classes.

Sociocultural history

- Economic status: Amount and/or source of income, type of health insurance coverage, perception of adequacy of income to meet needs
- Home environment.
- Client‘s role in the family.
- The cultural aspects of the client‘s lifestyle, health beliefs, and health practice